AND PUAN OF CORRECTION INTERCEPTION OF CORRECTION A SULCING NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX INTERCEPTION NUMBER INTERCEPTION NUMBER X475032 SUMMARY STATEMENT OF DEFICIENCIES INTERCEPTION NUMBER X475032 SUMMARY STATEMENT OF DEFICIENCIES INTERCEPTION NUMBER X475032 SUMMARY STATEMENT OF DEFICIENCIES INTERCEPTION NUMBER X475032 INTERCEPTION NUMBER STREET ADDRESS, CITY, STATE, ZIP CODE 125 NORTH STREET BENNINGTON, VT 05201 PERVIX TAG PROPRIES OF THE SUMMARY STATEMENT OF DEFICIENCIES INTERCEPTION NUMBER X475032 INTERCEPTION NUMBER INTERCEPTION NUMBER F 000 INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 11/8/11, and completed on 11/7/11. There were regulatory violations identified as a result. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to assure that resident transfer equipment was maintained in proper working condition. Findings include: Per review on 11/8/11, a letter received at the Division of Licensing and Protection written 9/30/11 stated that some of the mechanical lifts being used to transfer residents were not working properly, a discharged battery making it inoperable in either direction. In another letter dated on 10/4/11, it was stated that the lift was being operated without a safety strap that secures the residents sept to the lift machine, and the proper functioning during the monthly Preventative Maintenance (Attachment A2) Monitoring. MAINTENANCE SERVICES The facility must provide housekeeping and protection written proper functioning during the monthly Preventative Maintenance. (Attachment A2) 2) All Staff will be re-educated on the facility is policy and procedure for Maintenance Requests. (Attachment A2)	CLIVII	ERS FOR MEDICAR	H AND HUMAN SERVICES			FORM	: 12/02/201 APPROVE
STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET SUMMARY STATEMENT OF DEFICIENCIES 10 PREFIX FRODUCES 10 PREFIX FRODUCES 10 PREFIX 10 PREF	19 TO SWENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039	
VERMONT VETERANS HOME SUMMARY STATEMENT OF DEFICIENCIES 125 MORTH STREET BENNINGTON, VT 05201	NAME OF PROVIDER OF SUPPLIES			B. WING _		С	
SUMMAY STATEMENT OF DEFICIENCIES FOOD INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing and protection on 11/8/11, a letter received at the Division of Licensing and properly, a discharged batter gray and properly, a discharged batter gray properly, a discharged batter gray properly and properly				3	325 NORTH STREET	11/1	7/2011
An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 11/8/11, and completed on 11/17/11. There were regulatory violations identified as a result. F 253 SS=D MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to assure that resident transfer equipment was maintained in proper working condition. Findings include: Per review on 11/8/11, a letter received at the Division of Licensing and Protection written 9/30/11 stated that some of the mechanical lifts being used to transfer residents were not working properly, a discharged battery making it inoperable in either direction. In another letter dated on 10/4/11, it was stated that the lift was being operated without a safety strap that secures the residents legs to the lift machine. Per observation on 11/8/14, and their proper working condition. Provedure for Maintenance Requests. (Attachment A2) Moaitoring: Correction does not constiture any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Facility's continued compliance with all applicable laws. F 253 Corrective Action: The facility must provide housekeeping and maintenance and interviews, the facility ensures all mechanical lifts are maintained in proper working condition. Other Residents: All Residents who require the use of a mechanical lift batteries will be replaced yearly and PRN and their proper functioning will be monitoring during the monthly Preventative Maintenance. (Attachment A1). 2) All Staff will be re-educated on the facility's policy and procedure for Maintenance Requests. (Attachment A2)	PREFIX	! (EACH DEFICIENC	Y MUST BE PREASOED by FILL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	II A BE	COMPLETION
transfer of Resident #1, this surveyor observed the battery meter on the lift read approximately 3/4 full charge on it, and witnessed that the lift did not have the strength to operate properly to either lift the resident or lower him/her back down to the chair. The resident stated that this was a situation that had occurred several times before with more 1) The Maintenance Director or designet will conduct monthly audits, x 3 months, of all Preventative Maintenance of the facility's mechanical lifts to ensure all repairs have been completed. (Attachment A3)	F 253 SS=D	An unannounced of was conducted by Protection on 11/8/11/17/11. There we identified as a result 483.15(h)(2) HOUS MAINTENANCE St. The facility must promaintenance service sanitary, orderly, and This REQUIREMENT by: Based on record resistent transfer equipment of the facility resident transfer equipment of the proper working concentration of Licensing 9/30/11 stated that she being used to transfer of the properly, a discharging inoperable in either dated on 10/4/11, it being operated with secures the resident on 11/8 transfer of Resident the battery meter on full charge on it, and have the strength to the resident or lower the strength or lower the strength to the resident or lower the strength to	onsite complaint investigation the Division of Licensing and 11, and completed on the regulatory violations lt. SEKEEPING & ERVICES ovide housekeeping and these necessary to maintain a led comfortable interior. It is not met as evidenced eview, resident and staff the failed to assure that uipment was maintained in dition. Findings include: 11, a letter received at the grand Protection written some of the mechanical lifts her residents were not working ed battery making it direction. In another letter was stated that the lift was out a safety strap that its legs to the lift machine. Per //11 at 1:50 PM, during a #1, this surveyor observed in the lift read approximately 1/2 is witnessed that the lift did not operate properly to either lift in him/her back down to the		Please note that the filing of this correction does not constitute any admission as to any of the allege violations set forth in this Statem Deficiency. The POC is being fill evidence of the Facility's continuous compliance with all applicable la F253 Corrective Action: The facility ensures all mechanica are maintained in proper working condition Other Residents: All Residents who require the use mechanical lift for transfers are at Systemic Changes: 1) All mechanical lift batter will be replaced yearly a PRN and their proper functioning will be moniduring the monthly Preventative Maintenance (Attachment A1). 2) All Staff will be re-educed on the facility's policy as procedure for Maintenance Requests. (Attachment A1). Monitoring: 1) The Maintenance Directed designee will conduct me audits, x 3 months, of all Preventative Maintenance the facility's mechanical to ensure all repairs have	y d d dent of ed as ued nws. al lifts c of a t risk. ries and ditoring ce. ated ace A2) or or onthly l ce of lifts c been	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

Any deficency statement ending with a asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/02/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING 475032 B. WING 11/17/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **VERMONT VETERANS HOME** 325 NORTH STREET BENNINGTON, VT 05201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 253 | Continued From page 1 The Maintenance Director or F 253 than one lift. Staff was able to use the emergency designee will conduct 3 weekly audits, x 60 days, of release button to lower the resident to the chair. Maintenance requests to Per interview with the staff conducting the ensure maintenance requests have been responded to. transfer, they stated that they had reported the (Attachment A4) weak performance of the lift to maintenance verbally, however had not put in a written work Audit results will be reported order regarding this matter. They also confirmed at the bimonthly OA meeting. at this time that they had to use the lift without the leg safety strap at times in the past when the plastic buckle was broken that secured the Compliance Date: resident's legs to the lift. Per interview on 11/8/11 December 14, 2011 at 2:15 PM, the maintenance personnel who was identified as the one who maintains the F253 POC accepted | Karen Campoz RN 12/15/11 mechanical lifts, stated that he had started a monthly preventative maintenance program on October 26, 2011 to examine all the lifts in the building for proper performance, and showed me the checklist used to inspect the machines, not only for function, but also for proper storage and cleaning of the equipment, and acknowledged that there had been some problems with the lift not operating at full strength sometimes. Per telephone interview on 11/17/11 at 11:10 AM, the Director of Maintenance stated that the policy to alert maintenance of a problem that needs their attention is to write a work order in a book that is available at each unit's nursing station. Maintenance checks the books at least daily and usually more than daily, and also have followed up on items that were only relayed verbally to them. The monthly preventative maintenance program was started in October 2011, however before that time the mechanical lifts were

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maintained when staff reported a problem, and not routinely examined on a monthly basis.

483.25 PROVIDE CARE/SERVICES FOR

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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AND BLAN OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
	475032			B. WING			С	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS SITE			17/2011	
	INT VETERANS HOME	·		325	EET ADDRESS, CITY, STATE. ZIP CODE 5 NORTH STREET ENNINGTON, VT 05201	Ē		
PREFIX TAG	(LACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	MOULDE	(X5) COMPLETION DATE	
	Each resident must provide the necessa or maintain the high mental, and psychos accordance with the and plan of care.	F 3	09	F309 Corrective Action: Per MD's orders Resident #1 wraps have been discontinued Other Residents: All Residents with orders for specialized edema wraps are				
	Based on record revised to provide the to attain or maintain physical well-being for	view and interview, the facility necessary care and services the highest practicable for one resident regarding a nt for edema. (Resident #1)			Systemic Changes: 1) The facility staff ha educated on the facility Refusals of Treatment Medications Policy (Attachment B1) 2) Prior to the start of e wraps for any facility The facility will ensuadequate amount of the prior to the start of the star	lity nts and dema y resident, ure an staff have		

Per record review on 11/8/11, Resident #1 was admitted with a medical condition that requires a specialized dressing for compression to treat a type of edema. The facility arranged for the Physical Therapist who had been treating the resident before the nursing home admission to come to the facility and instruct staff on the proper method of dressing the leg to reduce edema. On 6/28/11, the therapist video taped the procedure with the resident's permission, as well as left detailed written instruction for staff to perform the dressing change properly. Perinterview with Resident #1 on 11/8/11, three nurses were present at the training session with one of them holding the camera while the physical therapist demonstrated the procedure. In the opinion of the resident, the three nurses are all competent in the dressing procedure, and the resident accepts care from these three nurses

Monitoring:

ordered.

1) The Clinical Care Coordinator will conduct 3 weekly audits x 60 days of Resident #1's TAR to ensure that reasons and patterns of refusals are addressed with the Resident and interventions

3) The Clinical Care Coordinators

TARs house wide to ensure

that reasons and patterns of refusals are addressed with the

Residents and interventions.

indefinitely. (Attachment B2)

documented to continue

will conduct weekly audits of

_CENTE	(TMENT OF HEALT (RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			•	PRINTE	D: 12/02/2019 MAPPROVED
POINTEMEN	IT OF DEFICIENCIES	L & MEDICAID SERVICES				OMB N	D. 0938-0391
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NAME OF	PROVIDER OR SUPPLIER					11/	17/2011
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(X4) ID PREFIX TAG	I (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HINDE .	(X5) COMPLETION DATE
	procedure, althoug attempt the dressin not comfortable with the procedure and due to the potential incorrect application. Per review of the misheets, there were the documentation, had not been applies side of the sheets ecombination of supdry or in laundry), okept a daily log of with the log of the treatment sheet only one day where coincide with the log october 2011 for existency one day where coincide with the log october 2011 for existency on 10 days (Oct. 1, 3, 4, 5, 7, 8, blank spaces with misheet on October 19 the case in September 30 days had circled to indicate the dress interview on 11/8/11 trained to complete confirmed that there who has been trained to provide the care, responds well with ownapped correctly of	ng. On occasions where the not been trained in the proper in the nurse was willing to g change, the resident was in un-trained staff performing would refuse to allow them to, for tissue damage from	F3		documented. (Atta B3) 2) The DNS or design conduct weekly aut 60 days, of all new for edema wraps to staff education has place and to ensure adequate amount of have received train the application of the wraps. (Attachment 3) The DNS or design conduct 1 weekly at 860 days of Reside TAR and dressing supplies to ensure compliance. (Attachment B5) Monitoring audit rewill be reported to bimonthly QA meet Compliance Date: December 14, 2011	mee will adits, x orders o ensure staken e an of staff aing on the t B4) nee will audit ent #1's chament esults ettings.	16/11

STATEMEN	RTMENT OF HEALT ERS FOR MEDICAR NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID S	(X2) MULTIPLE CONSTRUCTION				PRINTED: 12/02/201 FORM APPROVE OMB NO. 0938-039			
IDENTIFICATION NUMBER:				A. BUILDING				(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	475	B. WIN	IG			c			
	NT VETERANS HOMI				325	NORTH STRE		<u>11/</u>	17/2011	
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